ASSOCIATION OF SAFETY-NET COMMUNITY HOSPITALS

Written Testimony

ILLINOIS HEALTHCARE REFORM IMPLEMENTATION COUNCIL

November 16, 2010

The Association of Safety-net Community Hospitals submits the following written testimony to the Illinois Healthcare Reform Implementation Council for its November 16, 2010 hearing focusing on issues related to Medicaid Reform.

Our Association was organized to inform government entities and elected officials of the specific mission and needs of safety-net community hospitals in Illinois. Our mission is critical because, with very limited exceptions, we serve only the neediest members of society.

Within the City of Chicago, safety-net hospitals account for 37% of all Medicaid days. If public charity hospital services are excluded, our percentage of Medicaid days increases to 43%. Individually, some of our members are over 60% Medicaid. Clearly, by any definition, we serve a "disproportionate" share of our State's Medicaid clients.

Our safety-net hospitals are themselves needy because we have limited opportunity, if any, to cross subsidize with commercial business; yet we face daunting financial pressures from rising costs (principally labor, pharmaceuticals, and malpractice coverage), significant charity care, an aging infrastructure, downward pressure on revenues and the need to keep pace with technology.

Among the critical issues safety-net hospitals face are the following:

1. Lack of capital for facility, technology, life safety, and equipment improvement and/or replacement;
2. Increasing numbers of uninsured and underinsured patients, including undocumented patients for whom there is no reimbursement source;
3. Disparity of cost vs. payment in Medicaid and Medicare funding;
4. Difficulty in recruiting and retaining staff physicians due to low payments and high malpractice, including the need to subsidize some specialities just to offer services. The shortage of physicians in specialty areas is especially acute;
5. Increased incidence of disease and complications due to lack of primary care access;
6. Difficulty in recruiting and retaining staff due to financial, benefit, and community safety conditions;
7. Cook County Health Services diminishment/fragility;
8. Increased cost of leveraging funds (negative bond outlook);
9. Increased mortality and morbidity due to lack of specialty care referrals;
10. Cost of providing cultural and language appropriate treatment and care management;
11. Increased education, medication, and follow up needs due to lower community health indexes; and
12. Decrease in or total inability to cost shift from better payment insured patients.

Our testimony is in response to item #1 from Director Hamos' November 4, 2010 email.

After January 1, 2014, the Affordable Care Act (ACA) will make approximately 700,000 more Illinoisians eligible for Medicaid by covering all people with incomes less than 133% of the Federal Poverty Level (now about $14,000 for an individual or $30,000 for a family of 4), with 100% federal funding for the first four years. What are the implications of the significant

expansion for the Medicaid program? Within the bounds of the State's fiscal condition, what changes would improve the Medicaid program?

1. What are the implications of this significant expansion for the Medicaid Program?

    a. Unfortunately, our revenues do not afford sufficient opportunity for facility, technology, life-safety, and equipment improvements and/or replacements. We are currently working to comply with ACA's "meaningful use" standards for technology, but we have additional capital pressures that must be met. An appropriate first step by the State would be to release the capital funds dedicated to various safety-net hospitals pursuant to Public Acts 96-37 and 96-39.

    b. It is not clear that ACA has adequately addressed staffing needs associated with increased service delivery, particularly with respect to nurses and other skilled providers. We respectfully request that the State take all steps necessary to make certain that we have a well-trained, healthcare workforce.

        With respect to physicians, it is extremely difficult to recruit in the areas served by the safety-net community hospitals. One of the greatest pressures relates to the high cost of malpractice coverage. In general, Medicaid rates for physicians, particularly specialists, are not adequate. Either rates have to increase or the cost of malpractice coverage has to be controlled. We suggest the State review the FQHC model and either indemnify physicians disproportionately serving Medicaid or impose caps.

        Invariably, once an increased percentage of the population has insurance coverage, whether through Medicaid or other coverage, lack of staffing at the community hospital level will drive service delivery to the tertiary and academic facilities. The resulting imbalance in the healthcare delivery system will be unsustainable.

    c. Similar to physicians, the current cost of malpractice coverage for hospitals is unsustainable. In addition, we are often forced to cover the physician's risk before they will agree to serve the hospital. Many of our member institutions have been forced to self-insure all or a significant portion of malpractice risk. This places us one significant verdict from having to significantly curtail services or face closing.

        Please know that our insurance cost pressures are not the result of inferior quality. There is often a perception that the quality of service at inner-city community hospitals is inferior. This is not true. We are monitored for quality and consistently earn high marks. To the extent there is any disparity, it lies with the difficult population we serve, particularly including rapidly growing caseloads needing mental health and substance abuse treatment. Unfortunately, this problem has been exacerbated by the State's failure to adequately serve this population, causing them to present at our hospital emergency rooms.

d. We are concerned that the State's underfunded base rate structure will create an unfortunate anomaly for Medicaid expansion. Even though the federal government will initially pay for the additional Medicaid lives, it will be doing so at the State's existing rate structure. Because the State's rate structure is well below cost, all of the new lives will be funded at rates below cost. If and when the State revises its base rate structure, it must also protect the integrity of the entire reimbursement methodology. Without funding from quarterlies and the hospital assessment, most of our members will close their doors. The current hospital assessment has a state-imposed sunset, but no sunset at the federal level. Accordingly, it is essential to protect the assessment by removing the State's sunset.

   Further, we face cuts to Medicare DSH that will significantly reduce revenues.

2. Within the bounds of the State's fiscal condition, what changes would improve the Medicaid Program?

   a. With all due respect, the State's Medicaid system cannot function within the bounds of the current fiscal condition. The Association of Safety-net Community Hospitals has publicly stated its support for an appropriate, balanced income tax increase. We are prepared to work to support any such initiative.

   b. As discussed above, it will be necessary to revise rate reimbursement and to provide tort reform.

Thank you for your consideration of our testimony. Please contact either of our Co-Chairpersons, Mark Newton or Sister Sheila Lyne for additional information or to address any questions. Mark can be reached at 773-907-1000, and Sister Sheila can be reached at 312-567-2019.